

Preparing for MACRA: A Comprehensive FAQ for Physicians

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CMS finalized its [Medicare Access and CHIP Reauthorization Act \(MACRA\) ruling](#) on October 14, 2016, which reforms the payment structure for Medicare clinicians and further paves the way for value-based care. For some, the very terms “MACRA” and “final rule” may be enough to induce dizziness. For others, knowing that MACRA comprises more than 2,400 pages of regulations could cause panic. And now there are looming concerns over the future of the Affordable Care Act (ACA).

Fortunately, as an outcomes improvement company, we are accustomed to working with a lot of data and changes. We’ve read the regulations. We’ve heard a lot of concerns about MACRA from the healthcare systems and clinicians we support. We’ve been sharing what we read from those regulations, but it’s clear there’s more to teach and learn in preparing for MACRA.

Regarding the ACA, the Nixon Law Group, a leading healthcare law firm, [reports](#) “It is still unclear whether Congress will act to completely repeal the ACA or, more likely, strip it or defund parts of it that are unpopular.” That said, [MACRA] is a separate piece of legislation, passed with bipartisan support, and though it will evolve, there is no indication as of now that it will be significantly changed or repealed.

THE CURRENT STATE OF MACRA AFFAIRS

The [2016 Survey of America's Physicians](#) from the Physicians Foundation shows that 48 percent of physicians plan to cut back on hours, retire, take a non-clinical job, switch to “concierge” medicine, or take other steps that would limit patient access to their practices. Breaking this down, 14.4 percent say they will retire in the next one to three years compared to 9.4 percent who said so in 2014. Meanwhile, 21 percent will cut back on hours and 13 percent will seek non-clinical jobs. Doctors are dogged by poor morale and invasive regulations, according to the survey.

According to the [Deloitte Center for Health Solutions 2016 Survey of US Physicians](#), 50 percent of respondents said they have never heard of MACRA, while 32 percent recognize it by name but are not familiar with its requirements. Twenty-one percent of self-employed or independent physicians said they are somewhat familiar with the law, compared to nine percent of physicians employed by hospitals, health systems, or medical groups owned by them.

Eight-in-ten say they prefer traditional fee-for-service (FFS) or salary-based compensation as opposed to value-based payment models, some of which qualify under MACRA’s alternative payment model (APM) track. Seventy-four percent of respondents believe that performance reporting is burdensome and 79 percent do not support tying compensation to quality, both requirements under MACRA. Fifty-eight percent of physicians say they would opt to be part of a larger organization to reduce individual increased financial risk and have access to supporting resources and capabilities.

Another survey conducted in November 2014 by Weill Cornell Medical College and the Medical Group Management Association (MGMA) was analyzed in a [March 2016 article](#) from Health Affairs. It found that physicians spend an average of 15.1 hours every week processing quality metrics. The same survey shows the time physicians spend processing quality metrics translates to an average cost of \$40,069 per physician, per year.

Health Catalyst conducted two separate but identical polls in May and November 2016, asking webinar attendees how ready they were to participate in MACRA. As Table 1 indicates, the state of readiness has improved, but not significantly.

	May 2016	November 2016
Not at all	12%	16%
Somewhat	23%	28%
Unsure	56%	43%
Ready	8%	11%
Very Ready	1%	2%

Table 1 How ready are you to participate in MACRA?
(Source: Health Catalyst Webinar attendee polling)

In their book, [Healthcare Disrupted](#), Jeff Elton and Anne O’Riordan write about three signs of disruption: new language, new economics, and a new future. MACRA fits right into this description. It is big on new language (think of all the new acronyms) and features new economics. Although doctors will still be paid the same way, bonuses and penalties will be based on performance. The new future requires all of us to think about the capabilities needed in this new environment, and the capabilities we already have that need to be reshaped. It’s time to disrupt. But we need to learn more before we get started.

FAQ: THE MACRA BUZZ

After the final ruling was announced, an [article](#) in the Wall Street Journal explained MACRA in very simple terms, describing it as the new rule for how Medicare pays doctors, that it’s a broader push to overhaul federal health spending, and that it includes new bonuses and penalties tied to performance. We’d love to keep the explanation this simple, but there are a lot of important details to discuss and understand. To keep them organized, we’ve taken a FAQ approach based on feedback we’ve received.

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Why is MACRA necessary?

Without the passage of MACRA, physicians could have been subject to negative payment adjustments that varied from year to year under the Sustainable Growth Rate (SGR). Additional penalties of 11 percent or more would have been applicable in 2019 under the [Meaningful Use](#), [Physician Quality Reporting System](#), and [Value-Based Medicine](#) programs. In contrast, under MACRA, with the repeal of the Sustainable Growth Rate, the reimbursement landscape has been stabilized. The largest penalty a physician can experience in 2019 is four percent. MACRA also provides incentives for physicians to develop and participate in different models of health care delivery and payment known as [Alternative Payment Models](#) (APMs).

What are the aims of the Quality Payment Program?

The [Quality Payment Program](#) (QPP) that exists under MACRA unifies several existing policies to support care improvement by focusing on better outcomes for patients, decreasing provider burden, and preserving independent clinical practice. The QPP also promotes adoption of APMs that align incentives across healthcare stakeholders. It advances existing efforts of [Delivery System Reform](#) to ensure a smooth transition to a new system that promotes high-quality, efficient care by unifying these legacy CMS programs.

How do payments work in the two tracks of the QPP?

In replacing the SGR, MACRA built in a modest annual inflationary increase of 0.5 percent until 2019, dropping to 0.25 percent starting in 2026. The base performance year for the QPP is 2017. After that, clinicians must enter the Merit-based Incentive Payment System (MIPS) or become an Advanced Alternative Payment Model (APM) Qualified Provider (QP). MIPS participants will be subject to a four percent bonus or penalty in 2019; five percent in 2020; seven percent in 2021; and nine percent in 2022. APM Qualified Providers will get an automatic lump sum participation bonus of five percent from 2019 through 2024.

Who is required to participate?

The list of eligible participants in the MIPS track extends well beyond physicians. It includes Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and groups that include clinicians who bill under Part B.

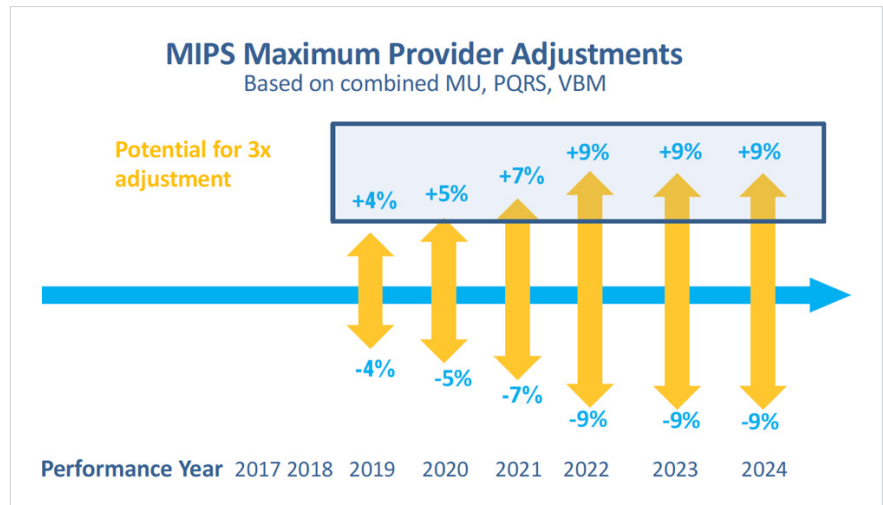


Figure 1: The penalty/bonus structure under MIPS.

Individuals who bill Medicare more than \$30,000 a year and provide care for more than 100 Medicare patients a year must participate in the QPP. Both requirements must be met. Approximately 14 percent of providers will be low volume and, therefore, not required to participate. Also, eligible physicians who are newly enrolled in Medicare are excluded from reporting in the first year.

Anyone already part of an Advanced APM will also participate. To participate in MIPS, providers must be a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified registered nurse anesthetist.

CMS estimates that between 592,000 and 642,000 eligible clinicians will be required to participate in MIPS in the 2017 transition year.

If I work in a large organization, do I need to worry about preparing for MACRA?

Reporting will not be automatic and physicians who work for large organizations shouldn't assume that their administration will shoulder this responsibility. There are many reporting requirements and it will behoove physicians to talk to leadership to verify exactly what they are.

What if I don't report at all?

Not reporting has its consequences, in addition to a four percent penalty. All data will be publicly reported through the [Physician Compare](#) website. Anyone contemplating sitting out should consider the potential impact not only on reimbursement, but also on future job search efforts, as well as reputation with prospective patients.

Should I report as an individual or group?

The rule defines a group as a single Taxpayer Identification Number (TIN) with two or more MIPS eligible clinicians, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN.

If you or your practice already participates in PQRS, then the election of submitting data as a group or individual has already been determined. Also, it is important to consider how you report. Claims-based quality reporting is allowed only if a clinician uses individual reporting, while only groups of 25 or more eligible clinicians may choose to report using the CMS Web Interface.

Submission requirements are different for groups and individuals. For example, CMS will apply the readmission measure to groups of more than 15 who meet the minimum volume of 200 cases. You must participate in MIPS as a whole, either as a group or an individual—not mixed. Group reporting performance will be assessed and scored across the TIN, and MIPS payment adjustments will be applied to the group level of the eligible clinicians in the group.

You can join virtual groups in the future once CMS has determined that definition. We should know more about this in early 2017.

What about multi-specialty practices? Should they report as a group or individually?

For most practices, it will be beneficial to report as a group. It's relatively easy to achieve measures, such as care coordination, that require effective communication among providers, patients, and specialists. Everybody can participate in this. Individual reporting in a multi-specialty group is an onerous process to address all the issues and will be quite confusing for the staff.

“Not reporting has its consequences, in addition to a four percent penalty. All data will be publicly reported through the Physician Compare website. Anyone contemplating sitting out should consider the potential impact not only on reimbursement, but also on future job search efforts, as well as reputation with prospective patients.”

To get the maximum score for 2017 do I have to report for the full year or can I just report for 90 days?

This depends on the quality of the data being submitted. The higher the data quality, the higher the score. Participants could report for the full year, but with low performance in all measures and still score lower than participants who report for 90 days with high performance in fewer measures.

The 90-day option can begin at any point in 2017. The 90-days must be consecutive and reporting must be submitted by March 2018. This provides flexibility for participants who cannot ramp up in time for the beginning of the year.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

What are the primary benefits of participating in MIPS?

MIPS offers the first real opportunity for physicians to earn substantial bonuses for providing a higher quality of care. Additional funding is provided for separate bonuses of up to 10 percent for exceptional performance (up to \$500 million per year) from 2019 through 2024.

It's a streamlined performance reporting system, which should be more easily managed than the existing multiple reporting systems. CMS currently allows group practices to report via the [qualified clinical data registry](#) starting in 2017, and MACRA encourages eligible professionals to use these registries for MIPS reporting.

Other benefits of MIPS participation include an improved performance scoring system that features a sliding scale assessment and offers a flexible selection of measures with flexible weighting to accommodate many practice types.

Also, small practices will receive \$100 million in technical assistance, money set aside for training to help them comply and participate in MIPS. From fiscal years 2016 through 2020, \$20 million per year will assist practices of up to 15 professionals to participate in the MIPS program or transition to new payment models.

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How does the Composite Performance Score work in MIPS?

Scoring for MIPS participants will be based on four performance areas, as displayed in Table 2.

For the first year, the Cost category has been removed, but it will return in 2020 weighted at 10 percent and growing to 30 percent over time.

Area	Weight in 2019 (changes each year)
Quality	60%
Cost	0%
Improvement Activities	15%
Advancing Care Information (formerly MU)	25%

Table 2 MIPS performance categories and weight attributions.

What are the participation levels under MIPS?

The transition year of 2017 is about picking a level of participation. There are four options:

- 1 Sit it out:** Non-participants in the QPP (those who don't submit any data) will be penalized four percent.
- 2 Test the waters:** Clinicians who send the minimum amount of data, such as a single Quality measure or Improvement Activity for any point in 2017, can avoid a downward payment adjustment.
- 3 90-day participation:** There are three components to this level. Choose one or all three.
 - › Report on one Quality measure as an individual; more measures are required if submitting as a group via the CMS Web Interface.
 - › Report on one high-weight measure in the Improvement Activities performance category.
 - › Report on five Advancing Care Information measures.
- 4 Full Participation:** There are three mandatory sets of requirements to this level.
 - › Report on six Quality measures or one specialty-specific or subspecialty-specific measure set. One of these should be an outcome measure, if available. If not available, then report on a high-priority Quality measure.
 - › Report on four medium-weight or two high-weight measures in the Improvement Activities performance category.
 - › Report on five Advancing Care Information measures; potential bonus for additional measures.

Full-year participants will potentially qualify for the four percent bonus, while minimal participation will avoid a negative adjustment. Bonuses and penalties rise in subsequent years. The more you do in 2017, the easier the subsequent years will be.

Summary of Reporting Options				
No Reporting	Minimal Reporting	Partial Reporting	Full Reporting	Advanced Reporting
Maximum negative adjustment of 4% in MIPS.	Report some data in 2017 to the Quality Payments Program (QPP)	Participate for part of 2017	Participate for all of 2017	Participate in an Advanced APM
	Protected from negative payment adjustment in MIPS, but no positive payment adjustment available either	Eligible for positive payment adjustment	Doctors who begin reporting data on January 1st 2017 will be eligible for a “modest” pay increase in 2019	Doctors who begin reporting data on January 1st 2017 will be eligible for a “modest” pay increase in 2019
	The specific measures have defined what “some data” actually means	Protected from negative payment adjustment	Data on quality measures, use of technology and practice improvement must be reported	Data on quality measures, use of technology and practice improvement must be reported
	CMS considers this a test of how doctors will be ready for more intense reporting requirements in the following years	Participants will be testing their systems for future MACRA compliance and may end up with a small Medicare pay increase		

Table 3 A summary of the reporting options under the new MACRA rule.

How would scoring look with minimal participation under MIPS in year one?

In this example, Individual A submits one quality measure with low performance (max possible points = 60), no Improvement Activity data (max possible points = 40), and no Advancing Care Information data (max

possible percent = 100). Remember, cost has been removed for year one. The formula, with category weighting, is shown below and the result is a Composite Performance Score of three points.

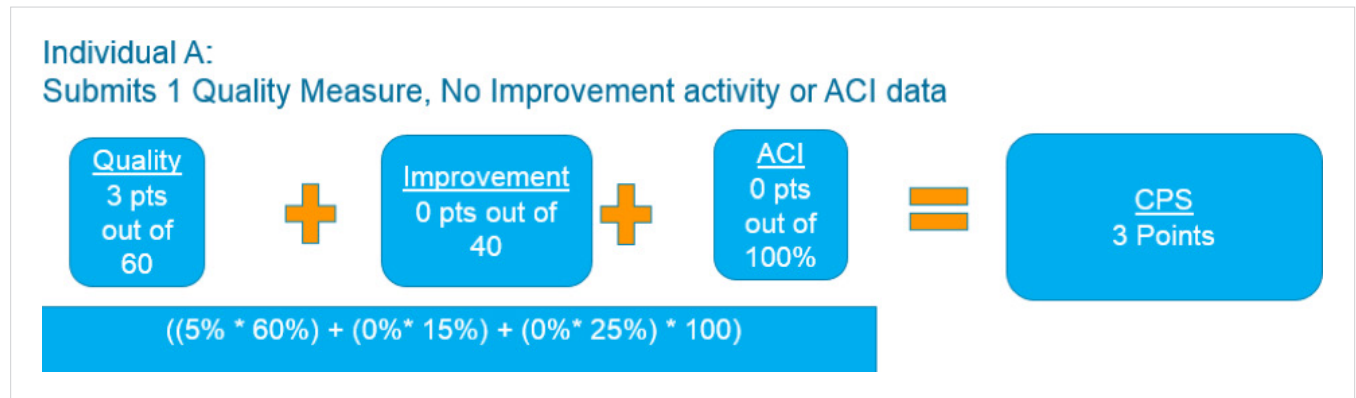


Figure 2: The Composite Performance Score for minimal participation by an individual under MIPS in year one.

Given all this math, the net result is neutral, meaning this individual wouldn't receive a bonus given that the minimum performance threshold is three points (think of it as a reserve). And a penalty is avoided simply by participating.

For a second example, let's look at a group practice that only submits one Improvement Activity measure with low performance. The formula shows a result of 3.75 points in the Composite Performance Score, with a neutral adjustment (no bonus or penalty).

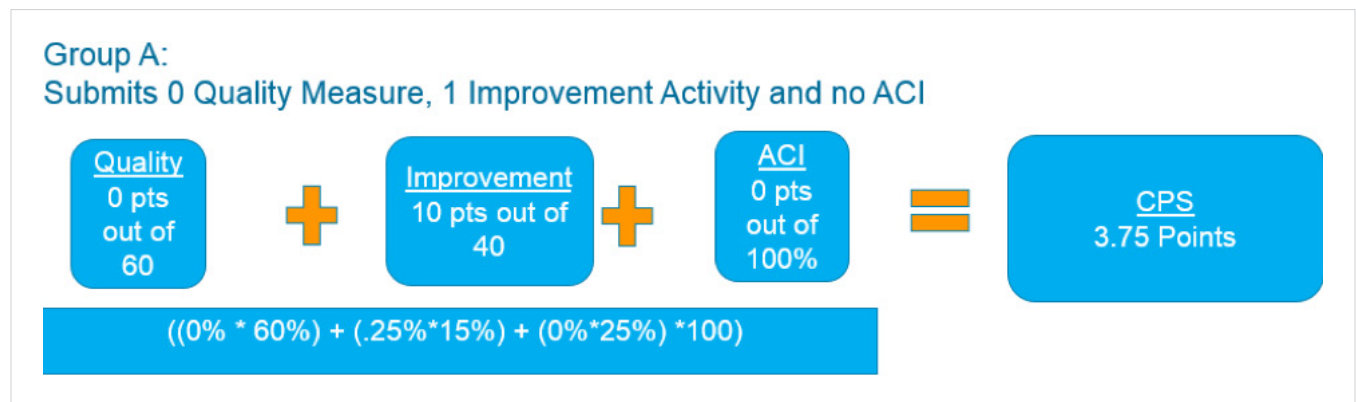


Figure 3: The Composite Performance Score for minimal participation by a group practice under MIPS in year one.

Finally, let's look at an example of full participation, for either an individual or group practice in year one. In this example, the participant is obligated to submit six Quality measures, four Improvement Activities, and five Advancing Care Information measures. The formula turns out a score of 76 points—good news because clinicians who achieve a final score of 70 or higher will be eligible for the exceptional performance adjustment, funded from a pool of \$500 million.

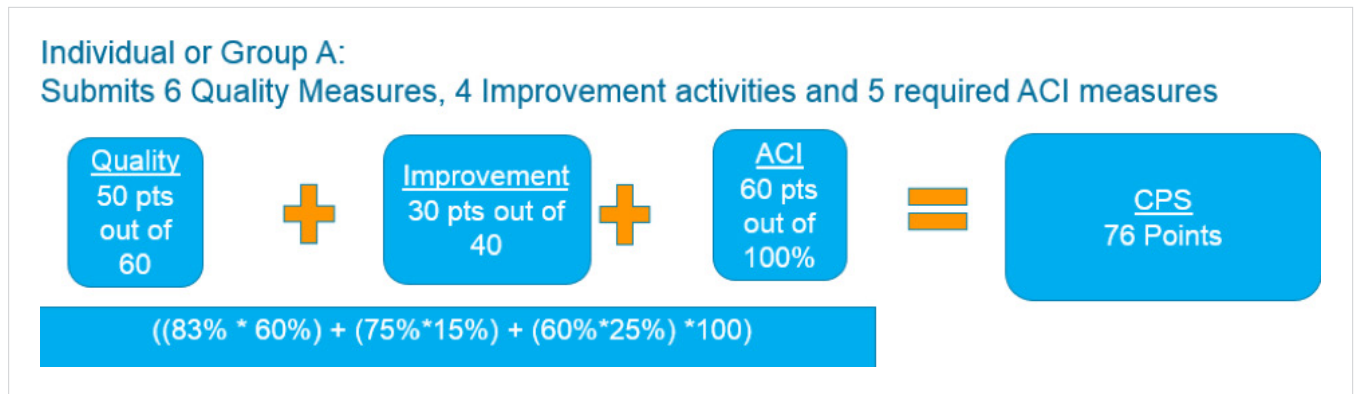


Figure 4: The Composite Performance Score for full participation for an individual or group under MIPS in year one.

How do I decide which Quality measures to report?

[Quality](#) performance accounts for 60 percent of the composite score in year one. There are [271 Quality measures](#) over 30 specialties, so choosing which ones to report comes down to familiarity. What is the organization already reporting on? Also, keep in mind that CMS is aligning Medicaid measures, payer measures, and measures from the [Core Quality Measures Collaborative](#). This will reduce the number of required variations of submissions. Continue with successful measures under MACRA, for example, quality initiative measures around screenings and immunizations, especially if your organization is already focusing on these.

How do I decide which Improvement Activities to report?

[Improvement Activities](#) performance accounts for 15 percent of the Composite Performance Score in year one. There are 78 medium-weight and 14 high-weight measures among eight categories in this area. Again, choose by what your organization is already doing. Is it participating in a registry, a health information exchange, or programs (e.g., [Million Hearts](#) initiative, [Transforming Clinical Practice Initiative](#), [Consumer Assessment of Healthcare Providers and Systems Survey](#))? Does it do domestic or international volunteer work for 60 or more days a year? Align existing activities with MIPS-required Improvement Activities to gain economies of scale.

How do I decide which Advancing Care Information measures to report?

The [Advancing Care Information](#) performance category focuses on the secure exchange of healthcare information and the use of a certified EHR. It accounts for 25 percent of the Composite Performance Score in year one. There isn't much choice in this category. Of the 15 measures, only five are required and account for 30 percent of the category score. Two bonus measures, both yes/no questions, add another 15 percent to the category score.

Year one, 2017, is a transition year. CMS expects this program to evolve, so stay aware of the changes (especially as CMS works to support multipayer alignment). CMS has a goal of aligning reimbursement with value. MIPS rewards providers for efficiency in achieving good outcomes while creating accountability for substandard care.

What changes did the Final Rule make to how providers are defined?

The Final Rule changed a few criteria for how hospital-based and non-patient-facing providers are defined in unique situations. The changes are in bold below.

Hospital-Based provider:

- MIPS eligible clinician furnishes 75 percent (**changed from 90 percent in the proposed rule**) or more of covered professional services in an inpatient hospital, on-campus outpatient hospital (**this site was added**), or emergency room setting in the year preceding the performance period. The Final Rule lowered the threshold from 90 to 75 percent and added the as a site of service.

Non-Patient-Facing provider:

- Individual MIPS eligible clinician who bills 100 (**changed from 25 in the proposed rule**) or fewer patient-facing encounters (including Medicare telehealth services) during the non-patient-facing determination period.
- A group where more than 75 percent of the NPIs billing under the group's TIN meet the definition of a non-patient-facing individual MIPS eligible clinician during the non-patient facing determination period (**methodology for identifying a non-patient-facing group was changed**).

ADVANCED ALTERNATIVE PAYMENT MODEL (APM)

What is an Advanced APM?

An Advanced APM can apply to a specific clinical condition, care episode, or population. Advanced APMs allow practices to earn a five percent incentive payment for assuming some risk based on patient outcomes.

CMS has the goal of shifting 90 percent of Medicare payments to quality or value by 2018 and the APM is the vehicle for doing this. There is a potential for expanding this to other payers after the first year. Other goals include better care, smarter spending, and healthier people.

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CMS released an evolving [list of organizations](#) that they designate as eligible entities in this area.

What are the components of an Advanced APM?

Advanced APMs are defined by three requirements:

- Participants must use a [certified electronic health record technology](#) (CEHRT).
- Payment must be based on quality measures comparable to those under MIPS.
- Participants must bear risk for monetary loss or the APM must be an expanded Medical Home Model under [CMS Innovation Center](#)

What models qualify for an Advanced APM?

CMS has established this short list of entities that qualify as Advanced APMs:

- [Comprehensive ESRD Care Model \(Two-Sided Risk\)](#)
- Medicare Shared Savings Program—[Track 2](#) and [Track 3](#)
- [Next Generation ACO Model](#)
- [Comprehensive Primary Care Plus \(CPC+\)](#)
- [Oncology Care Model \(Two-Sided Risk\)](#)

What are the parameters of financial risk under an Advanced APM?

During specific time periods, CMS will compare expected and actual expenses. A penalty is applied if actual expenses exceed expected. The penalty can be in the form of withheld or reduced payments, or the APM entity could owe a payment to CMS. When actual expenses come in lower than expected, the APM entity receives a bonus.

The Medical Home Model has a separate financial risk standard with many criteria, but it must have a primary care focus and patients must be empaneled with a primary care physician. Also, there are requirements for patient access, care coordination, care management, and shared decision making. The payment arrangement is that 2.5 percent of Medicare Part A and Part B must be at risk.

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What are the other pathways to performance-based risk?

The list is still growing, but includes five entities:

- New Medicare ACO Track 1+ Model for 2018
- New Voluntary Bundled Payment Model
- Comprehensive Care for Joint (CEHRT)
- Advancing Care Coordination thru Episode (CEHRT)
- Medical Home Model

CMS predicts that 25 percent of physicians will follow one of these pathways by 2018.

What is the process for becoming a Qualified Participant (QP) under an Advanced APM?

Participants must first be an APM, then an Advanced APM, then an entity within the Advanced APM, and, finally, a QP. It is estimated that between 70,000 and 120,000 providers will be QPs in 2017.

What are the binding parameters for a QP in 2019?

- At least 25 percent of total payments come from the Advanced APM (payment amount formula), or
- At least 20 percent of patients come from the Advanced APM (patient count formula). Professional services furnished at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) that meet certain criteria are counted toward the QP determination using the patient count formula.

What are the binding parameters for a Partial QP in 2019?

A Partial QP has lower parameters under the Advanced APM:

- At least 20 percent of total payments come from the Advanced APM (payment amount formula), or
- At least 10 percent of patients come from the Advanced APM (patient count formula).

At least 20 percent of patients come from the Advanced APM (patient count formula). Professional services furnished at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) that meet certain criteria are counted toward the QP determination using the patient count formula.

Partial QPs are eligible to select the MIPS track, but Advanced APM QPs are not obligated to MIPS and they receive the five percent incentive payment for 2019.

FINANCIAL ASSISTANCE FOR TRAINING AND EDUCATION IS AVAILABLE

The intent of MACRA is not to save money just for the sake of saving money, but to incorporate financial incentives in order to take care of patients in a more efficient way and to give them the benefit of a quality clinical experience.

As mentioned earlier, MACRA will provide \$100 million to fund training and education (\$20 million each year for the next five years), beginning December of 2016. Individual or small group practices of 15 or fewer clinicians, and those working in underserved areas, are eligible to receive this training. This education will be conducted through local, experienced organizations that will use the funding to help small practices select appropriate quality measures and technology to support their unique needs, train clinicians about the new improvement activities, and assist practices in evaluating their options for joining an Advanced APM.

More information is available from several organizations:

[American Medical Association](#)

[American Hospital Association](#)

[American Academy of Family Physicians](#)

[Office of the National Coordinator list of certified vendors](#)

[CMS Quality Payment Program](#)

Focus on Strategic Planning in Four Key Areas

To start preparing for MACRA today, focus on evaluation and strategic planning in four key areas:

Financial – For 2017, stabilize and optimize your revenue stream to make sure your practice isn't leaving money on the table. Make sure you are conducting self-audits and GL management to help plug any revenue leaks. Scrutinize your [reimbursements](#).

The intent of MACRA is not to save money just for the sake of saving money, but to incorporate financial incentives in order to take care of patients in a more efficient way and to give them the benefit of a quality clinical experience.

Clinical – 60 percent of your MIPS score is based on Quality targets, so pay attention to this scoring category and take advantage of all the measures spread across multiple domains. Also, focus on the measures on which you already report. Remember that [population health](#) and care coordination are at the heart of the QPP, so focus on expanding communication with your beneficiaries, patient care teams, and specialists.

Technical – Success here is key to MACRA, so make sure you can access information through your EHR templates, that your workflow is customized, and create dashboards for easy visualizations.

Staff Training – To help shoulder this burden, practices may need to align with partners that have expertise in program implementation, staff training, and educating stakeholders along the continuum.

Success here is key to MACRA, so make sure you can access information through your EHR templates, that your workflow is customized, and create dashboards for easy visualizations.

FOLLOW THROUGH WITH SEVEN STEPS TO PREPARE FOR MACRA

With the strategic plan in place, follow through with these seven steps to ensure a smoother transition to the new payment structure.

#1: Determine Your Status

Use the American Medical Association's [payment model evaluator](#) to find out if you qualify for the MIPS or Advanced APM tracks, or are exempt.

#2: Decide on Individual Vs. Group Reporting

If you practice with more than one eligible clinician, decide whether it's more beneficial for you to report individually or as a group. If you report as a group, you will have less flexibility on which measures to report.

#3: Determine Accommodations

Determine whether you meet the requirements for small, rural, or non-patient-facing physician accommodations.

#4: Target Specific Improvement Areas

Access and review the 2014 annual PQRS feedback reports to see where you can make improvements. If you don't have data on certain measures or you haven't reported on them before, then it will be difficult to start reporting on them for 2017. Pick measures on which you are already reporting.

#5: Leverage Data Registries

Data registries can streamline reporting and assist with MIPS performance scoring. Find out if you are participating in a qualified clinical data registry. If not, contact your specialty society about participating in theirs.

#6: Start Preparing Now

CMS is committed to providing feedback reports in the summer of 2017. They won't have all of the data, but they will have some data pulled primarily from claims. Review in 2017 for 2020 ramifications (attribution). Look at 2017 as an opportunity to test your systems and processes in preparation for the increasing bonuses or penalties coming in the later years of MACRA.

#7: Decide How to Report

Finally, make sure you know how you are going to report, whether it's through claims, an EHR, clinical registry, qualified clinical data registry (QCDR), or group practice reporting option (GPRO) Web Interface. Keep in mind that the GPRO Web Interface is only available for physicians in practices of 25 or more eligible clinicians.

ACT NOW, BENEFIT LATER

The first performance year for MACRA is upon us and, for physicians who will participate, the time to prepare is now, regardless of the chosen reporting option. This is a new world order for Medicare reimbursement and there are many new processes to manage. The ACA is facing an uncertain future. Although potential repeal will not affect MACRA and the QPP, Medicare and other legislative changes could. Regardless, reporting efficiencies and prospective revenue enhancement await those who are diligent in getting organized now. 💡





**Dr. Bryan Oshiro, Chief Medical Officer
Senior Vice President**

Bryan Oshiro, MD joined Health Catalyst in January 2014 as the Medical Director. He received his medical degree and completed his residency in Obstetrics and Gynecology at Loma Linda University School of Medicine and completed his fellowship in Maternal-Fetal Medicine at the University of Texas in Houston before moving to Salt Lake City to join Intermountain Health Care and served as the Medical Director of the Women and Newborn Service line. He also was a member of the department of Obstetrics and Gynecology at the University of Utah. He then joined Loma Linda University where he became the division director of Maternal-Fetal Medicine and the vice-chairman for the department of Obstetrics and Gynecology. He co-chairs the American College of Obstetricians and Gynecologists Patient Safety Committee for District IX and received the Elaine Whitelaw Service Award from the March of Dimes for his work on a 5 state initiative to eliminate elective deliveries less than 39 weeks gestation.



**Bobbi Brown, Vice President of Financial
Engagement**

Bobbi Brown is the Vice President of Financial Engagement for Health Catalyst. Ms. Brown started her healthcare career at Intermountain Healthcare supporting clinical integration efforts before moving to Sutter Health and, later, Kaiser Permanente, where she served as Vice President of Financial Planning and Performance. Ms. Brown holds an MBA from the Thunderbird School of Global Management as well as a BA in Spanish and Education from Misericordia University. She regularly writes and teaches on finance-related healthcare topics.



Dorian DiNardo, Senior Data Architect

Dorian DiNardo joined Health Catalyst in July 2013. Prior to coming to Health Catalyst, Dorian worked for PeaceHealth as a Senior Data Warehouse Developer. Dorian has a Bachelor of Science Degree from Oregon State University and her PMP certification.



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